# Exhibit 1

Transcription of Video

ipbc_and_saveonsp_training-20210216_1901-1

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MS. GINTER: Okay. Well, thanks everybody for joining. This is the follow up session up to the Board discussion on the SaveOn SP Program that IPBC will be implementing on May 1st. This session came about as a result of some detailed conversations and some concerns about the program and the applicability, especially with respect to collective bargaining arrangements. 00:05 00:08 00:11 00:15 00:19 00:22 00:24 00:25 00:23

And needing to understand what this program does in a more detailed level so that each of the IPBC members can make decisions about whether or not this program needs to be rolled out to your particular member plan or not. There's some pretty significant savings here. 00:29 00:31 00:34 00:38 00:40 00:42

So IPBC, in general, is pretty excited about the program. It's a win win on behalf of the employee and the employer to take advantage of these manufacturer discount programs. But we do understand the caution that you have in considering these programs and the impact it may have downstream particularly with respect existing CBAs. 00:44 00:45 00:49 00:52 00:55 00:58 01:00 01:02

So we invited Express Scripts to come in 01:02

and facilitate the conversation today. They have about ten slides to walk through so you can understand what this program does in a little bit more detail. You will be asked -- if you are considering opting out of the program, you will be asked to complete an opt-out form by this Friday. The tight turnaround time on that one is being driven by the implementation calendar for Express Scripts. The overall program, we estimate is worth about $320,000 in savings a month to IPBC and those are some pretty big dollars that we wanted to implement as soon as possible.

But what that means is a pretty quick turnaround time for us to be able to manage that implementation schedule. So we're going to through the slides today and then you'll have the opportunity to ask your -- your questions throughout and then we will review. There is an opt-out form that is something that you'll need to complete if this is a program that you would like to not implement.

Two quick words, also, on the grandfather plans within IPBC will be carved out of this program. Because it is a change in -- in

benefit design, it would compromise the grandfathered status, so those plans will be carved out. There's also a question on HSA plans. It is looking possible that we will need to carve those out as well because we would want to make sure that we are in full compliance. 02:25 02:27 02:30 02:32 02:35 02:37 02:38

So that is something that we are working on determining over the next few days to see whether our HSA plans would also need to be excluded from this plan. Non-HSA plans, non-grandfathered plans are really the ones that are up for discussion today. And with that, I will hand it over to Tammy to introduce Rachel. 02:41 02:44 02:46 02:46 02:52 02:55 02:58 02:59

MS. RYKIEL: Good afternoon, everyone. Hope you're staying warm and safe in this crazy weather. So thank you all for the opportunity to come in and speak with you this afternoon. And Rachel Harmon is the product director over the SaveOn Program here at Express Scripts and really our subject matter expert. So we've invited Rachel to come in and review the presentation with you and assist with questions and answering any questions that you 03:03 03:05 03:08 03:10 03:15 03:16 03:18 03:23 03:26 03:28

may have. So with that, Rachel, I'm going to hand it off to you. And, Melissa, I assume you will be facilitating moving the slides along as we need to, correct? 03:32 03:34 03:35 03:39

MS. GINTER: That's right. 03:40

MS. RYKIEL: Right. Great. Thank you. 03:42

MS. HARMON: All right. Thanks, Tammy. And thanks, Melissa for that overview. I thought it would be good if we just took a moment to go ahead and go through the first slide which is a high-level overview of what SaveOn is. 03:47 03:49 03:51 03:53 03:56

So SaveOn is a program that's known in the industry as a copay off-set savings program which means that we're using the member copay as a mechanism to create savings for the plan at the point of sales. So that concept in of of itself is not unique in the industry. However, the way that SaveOn administers their program is. 04:01 04:03 04:06 04:09 04:12 04:15 04:17 04:19

So it's important to recognize that the way we operationalize the SaveOn offering is by understanding some of the key concepts as it relates to the Affordable Care Act and the Essential Health Benefits. So if you rewind back to 2012 when we were designating 04:22 04:25 04:28 04:31 04:34 04:35

ourselves as an essential health benefit under the ACA guidelines, there was a mandate that simply said you align yourself to a benchmark state and that benchmark state would then dictate how many benefits, drugs, and services you have to cover by therapeutic category to be deemed essential by the ACA. 04:40 04:44 04:47 04:49 04:50 04:54 04:57

So understating that requirement and by meeting that requirement what SaveOn has done is an extensive amount of work to understand all the state benchmarks, the therapy classes that we're targeting and the applicable drugs that we can effectively carve out and administer a different benefit design. 05:00 05:03 05:06 05:08 05:11 05:16 05:18

So under your existing benefit today we cover those essential health benefits as defined by your benchmark state by therapeutic category. There's no change there. But for a number of drugs, we can carve them out and create a different benefit design where we designate these drugs as non-essential. And this is a key differentiator for SaveOn. When you designate the drugs as non-essential, you do a couple of things. You remove the ceiling for how high you can set the member contribution. 05:20 05:23 05:27 05:29 05:33 05:35 05:38 05:41 05:44 05:47 05:49

So there's no maximum as to how high we can set the member responsibility which means that you are able to fully leverage all the manufacturer assistance dollars to offset your plan cost. So you can see in this example for the category of Hepatis C, the average amount of assistance per fill is $6,600. We would literally set the patient copay to $6,600 and you would save that amount on every fill.

The second piece is by definition non-essential health benefits are not applicable to your maximum out of pocket accumulators. Which means on -- in today's world your patients can use copay assistance and unless you have an accumulator adjustment program in place, like out of protect protection, any copay assistance dollars look like patient paid dollars.

And therefore, a lot of patients are able to meet their maximum out of pockets by using the copay assistance dollars rather than paying out of their own pocket. So what we've done here is, you know, it's kind of a nice -- I think as Melissa said - it's kind of a win-win because -- you know, if you put in an accumulator adjustment

program in place, patients get upset because if they've been receiving the benefit for a long time as hitting that max out of pocket then they feel like they have something taken away. Well in this scenario what we're doing is we're creating savings for the plan and we're keeping the patient responsibility at zero but we're just not going to allow that to hit their max out of pocket. 07:06 07:08 07:10 07:12 07:15 07:18 07:22 07:24 07:26

So there's not really much to complain about when you get your specialty drug for free. In fact, it's a pretty good incentive to want to participate in the program. And so therefore, the member wins, they get a very high-cost specialty medication at no cost to them. The plan gets a maximum cost offset at the point of sale from that manufacturer assistance program. 07:27 07:29 07:32 07:35 07:36 07:38 07:42 07:44 07:46

And further, the plan benefits because what would have happened in today's world with your existing benefit design is, this high-cost specialty drug, as soon as you increase the copay, it's going to push you into full placement mode much more quickly than you otherwise would have. So we feel like SaveOn is a true market 07:49 07:51 07:54 07:56 07:59 08:03 08:05

differentiator in the sense that we're maximizing plan cost savings, we're benefiting the member, and we're not disrupting the rest of the benefit design. So we've expanded this program pretty significantly over the last two years. We're now over to 270 drugs in the program. And that's how we're getting such significant savings for you all. Before I jump to the next slide, I'm just going to pause and make sure there aren't any questions as it relates to how we administrate our program different than others in the industry.

All right. Great. So if we want to go ahead and jump to the next slide. I think it's probably worth talking about this essential health benefit a little bit more. I know --

MS. GINTER: Hey Rachel, there's --

MS. HARMON: -- for a couple of reasons.

MS. GINTER: This is Melissa, there was a question posted. Are there any specialty drugs not covered in this savings program?

MS. HARMON: Yes. Good question. So if you remember I said previously we have to keep a certain amount of drugs in your existing benefit design which follow your standard plan in order

to stay compliant under the ACA. So we keep those required drugs in your existing benefit so they would still follow suit with your current plan design. And patients can still use copay assistance in those scenarios. It's just that you're not leveraging those savings dollars to create savings for the plan. 09:22 09:26 09:29 09:32 09:35 09:37 09:40

All right. So, I see another question came through, so now that I'm alerted to this chat feature, I will try to answer these questions as they come in. Okay. So when somebody picks up their prescription, does this mean they still pay the regular copay? So whenever we administer this program, we will have a set drug list with a corresponding copay schedule. So the copays will vary by drug, and that's because there's a different amount of assistance, depending on the manufacturer's program. 09:52 09:55 09:57 09:59 10:01 10:02 10:06 10:10 10:13 10:15 10:17 10:19

And so what they have to do -- what we do is we take the total amount of assistance per year, and we factor in some assumptions based on the general course of therapy for that medication and the typical fill schedule. So we set a copay that corresponds to, you know, if it's a therapy 10:21 10:24 10:29 10:31 10:34 10:37

that is typically taken once a month and we have 12 fills, and then we annualize the -- the total amount of savings, and then we divide it by 12 to get the monthly copay. 10:40 10:42 10:47 10:49

And then in terms of do they have to do they have to do anything special for the savings, yes, they have to opt into the program and enroll in copay assistance. So that is SaveOn's job. They own the member experience in educating them on the copay assistance program, how to enroll, and when possible, they walk them through those steps so that we can secure those assistance dollars. 10:52 10:54 10:56 10:58 11:03 11:07 11:10 11:12 11:15

And then is a list of specialty drugs that are included? Absolutely, and we have a targeted drug list that we can share with you again, and it will have the corresponding copays on it. What SaveOn does is they create a client-specific URL, which is then referenceable. So it can be placed in your summary plan description documents. You don't have to keep revising them every time the copay changes or if it changes or if the drug list changes. 11:17 11:20 11:22 11:25 11:30 11:33 11:36 11:39 11:41 11:44

And so when we send member communications, we send a letter that has the copay drug list as 11:47 11:55

the second page and as well as referenced on the URL as well. 11:58 12:00

All right. Let's see. I'm getting quite a a few. Can we see the member impact for our community? Yes, so I can share with you -- Tammy and I can work on getting member disruption for your specific group. The only thing I would -- you know, I would just say is to consider that there will be disruption in the sense that we have targeted members that need to be enrolled. We have a very good success rate in terms of getting patients to agree and to participate. Again, there's heavy incentive. They pay nothing for their specialty medication. And if anybody ever resists at any time, SaveOn does reach out to Tammy and I, which then would prompt us to reach out to you, and we can manage that member as they go through, you know -- as they go through that process. And if you guys feel like it's acceptable to make an exception, that is possible. 12:04 12:07 12:11 12:14 12:19 12:22 12:26 12:28 12:30 12:34 12:37 12:39 12:42 12:46 12:48 12:53 12:55 12:59 13:00

All right. If there's no copay, will this go towards the member's deductible? No, there is nothing in terms of patient paid money that gets to apply. How is it determined which 13:06 13:10 13:13 13:18

specialty drugs are to be part of SaveOn and those that are not? So like I said, SaveOn has done an extensive amount of work to understand one, fifty-state benchmark. Two, which programs have the most lucrative copay assistance programs to be able to leverage that savings. Then three, along with our Express Scripts preferred formulary strategies, we obviously don't want to incentivize the use of something that you -- of a product that you guys are not preferring. And so we worked hard to ensure that we're honoring those preferences because that upholds your rebate value, which is a separate pool of money than this copay assistance money.

So once we've determined by therapeutic category effectively how many drugs can be carved out and fall into the separate benefit design, we then look for what's the biggest utilization and what's the most money that's available in terms of creating savings to get to that SaveOn drug list.

Does the specialty drug list change from year to year? Yes. In fact, we evaluate the drug list constantly. We make designated changes on 1/1 and 7/1, unless there's a need to make an

interim change. So we haven't had to yet, but we reserve the right to, if something comes to our attention where the funding goes away completely or we have a significant change, we have the ability to remove drugs from the program. It would require extensive communication to the member, and -- and we would honor the -- the copay assistance or the -- the zero dollar SaveOn copay until we were able to effectively manage that patient out, manage that drug out.

But there is -- we knowingly make updates on 1/1 and 7/1, and if necessary, we could change it throughout the year.

How much time does it take to enroll in SaveOn? Is it a one-time enrollment? So initially, it's a one-time enrollment, and it depends on the copay assistance program. So generally speaking, copay assistance programs are good a year from the day of enrollment.

So once the member enrolls, we have the enrollment information and the claims should adjudicate and process at Accredo for zero dollars, as long as that copay assistance program is active. And the timing it takes

to enroll depends on the manufacturer and the requirements for participation. 16:02 16:05

Many of these are an online enrollment, which SaveOn can help facilitate with the member on the phone, and those generally take anywhere from 5 to 15 minutes to secure that assistance. Other manufacturers require a phone call from the member to, you know, complete that questionnaire live. So that may take a little bit longer, but SaveOn does manage that member experience and works with the members to help them both understand the goal of the program and what we're trying to accomplish here as well as how to respond to the questions that they're being asked as part of enrollment. 16:07 16:10 16:13 16:18 16:20 16:23 16:26 16:29 16:32 16:36 16:38 16:41 16:44

How do -- how long do the discounts apply? So copay assistance, again, is good for as long as the program is active and as long as they haven't exhausted the annual maximum. So as long as the enrollment is good, the -- the copay assistance will create savings for the plan for the duration. 16:48 16:52 16:54 16:58 17:00 17:03 17:06

Can a member opt out after opting in if their medication comes off the list? So if their medication comes off the list, the member 17:11 17:13 17:15

is opted out. There's no ability for us to then manage that patient through the SaveOn program. 17:20 17:25

So effectively, once the drug is determined to come off of the list, then we would communicate that date, and at that date the member would transition from the SaveOn plan design back to your original plan design, and so whatever your copay for a specialty is on your existing benefit will apply. 17:29 17:33 17:36 17:37 17:41 17:45 17:47

Can an IPBC member opt out now (inaudible) opt in for -- 17:47 17:55

MS. GINTER: That one's for me. Let me jump in there. 18:01 18:01

MS. HARMON: Okay. Sure. 18:02

MS. GINTER: Yeah, and I think that question has more to do with the IPBC rule. You would be allowed to opt out of the program. If you wanted to roll it out January 1st, 2022, that is possible, but note that your 7/1/21 renewal rates would not be adjusted for the savings. That would have to be factored into your 7/1/22 renewal. So you might not -- you wouldn't be able to realize the savings yet. So that is something to note. But you could decide to tell IPBC that you wanted to participate in 18:06 18:09 18:12 18:16 18:21 18:23 18:25 18:30 18:33 18:35 18:39

SaveOn on 1/1. Go ahead, Rachel. You can grab the next one. 18:44 18:45

MS. HARMON: Okay, thank you. So -- okay, somebody asked if the cost of a specialty drug is free for the member, where does the copay come into play? Excellent question. 18:50 18:53 18:55 18:57

So the way that this program is set up is in order for us to capitalize on this copay assistance funding, we have to have that inflated copay upfront to bill to copay assistance. So we set the copay, and we'll use an easy example of $1,000, just for the purposes of walking through how the claim is processed. 19:01 19:04 19:07 19:10 19:14 19:17 19:21

We'll say that we set the copay to $1,000. Before we ever communicate that there's a responsibility for the patient to pay, there's a prompt at Accredo that alerts the advocate that this is a SaveOn opportunity. 19:24 19:26 19:30 19:30 19:35

At that point in time, we know that we need to connect the patient to SaveOn so that they can enroll. So we always want the primary payer for these claims to be the plan. So IPBC is the primary payer, and that's because that drives formulary, utilization management protocols, and ensures that we're adjudicating 19:38 19:41 19:45 19:49 19:52 19:54 19:57

according to your rules first. Once that claim pays, that's when we return the inflated copay, which allows us to create savings for you. So the secondary billing process goes to pharma, and so that's where we bill pharma.

So typically speaking, the secondary payer would pick up the remaining amount less any required fees that they -- they have for participation in their program.

So some copay-assistance programs will say, we'll allow the patient to have up to $1,000 in copay assistance as long as they contribute $5 out of their own pocket. So that secondary bill in that example, we would bill them the 1,000, and they would pick up 995 and expect -- there's a -- be a patient responsibility.

And that's where we leverage something called a tertiary biller or the third biller who's technically SaveOn behind the scenes.

Because we want to keep the patient responsibility at zero, we have this third payer in play. That's any balance that copay assistance doesn't pick up, which always ensures that the member receives a zero dollar copay at the point of sale.

We have an example later in the deck, too, which I think might -- if you have further questions, might clear that up. 21:17 21:19 21:22

All right. What happens to a member's copay for a specialty drug not included in the program? Is it adjusted to compensate for the reduction in the included specialty drug? So if the drug is not included in SaveOn, it will follow your existing benefit design. So again, for example, if your specialty copay is $25 today, the specialty drug will still process, and the patient will have the responsibility of $25. 21:23 21:25 21:29 21:34 21:36 21:39 21:44 21:49 21:51 21:52

If they choose to use copay assistance, that's perfectly fine. They still can. They just won't get the drug for free as in the SaveOn example. 21:54 21:57 21:59 22:03

MS. GINTER: So Rachel, let's keep going with the presentation. I know -- I love all these questions coming in through the chat. I don't think I've ever seen this kind of engagement. It's fantastic. Let's keep going, and then we can pick up the questions. I think a lot of the questions may be answered a little bit further. 22:05 22:07 22:11 22:14 22:16 22:19 22:21 22:22

So we will make sure to get to all the questions, but let's keep going with the deck because I think that may head off the most -- where folks are coming with their questions. 22:25 22:27 22:30 22:32

MS. HARMON: Yes, I think that sounds great. So just a reminder, essential health benefits and nonessential. So again, the ACA defines the essential by, again, leveraging a state benchmark. You do not have to leverage your own current state or the state in which most of your members reside. It's simply a guideline for how to administer that essential health benefit. 22:34 22:38 22:43 22:44 22:48 22:51 22:56 22:59

So for example, many commercial plans picked Utah because it has the fewest number of required drugs to cover, and therefore it was the most cost effective. So all we're saying is that Utah is setting the list of drugs or the number of drugs by therapeutic category to be deemed essential. 23:01 23:03 23:06 23:09 23:13 23:15 23:16

Again, the differentiator being that those in the essential health benefit, all those ACA rules as it relates to max out of pocket, deductible, the -- the applicability to those accumulators, that's what houses all of those rules. 23:20 23:23 23:26 23:31 23:34 23:35

The moment we reclassify these as nonessential, we get to operate outside of those rules, which removes the limitations for how high we set the copay. It removes the requirement to apply copay assistance dollars to the max out of pocket. And that's what allows us to be the most lucrative in terms of driving savings for SaveOn. 23:37 23:39 23:41 23:44 23:47 23:50 23:53 23:56

And the next slide, yep, so just a reminder, so we're still at the core of this. We're still following all of your current formulary and utilization management protocols. Again, by making sure that the plan is the primary payer, that's what drives those first two components, formulary and UM first, because that's what protects and preserves your rebate value, again, a completely separate pool of money, also still protected. 24:04 24:07 24:10 24:13 24:16 24:19 24:22 24:25 24:28 24:32

So I always like to let clients know that, you know, the rebate agreement is between the rebate aggregator and the state's Express Scripts and the manufacturer. These copay assistance dollars is an agreement between the member and the manufacturer. It's a completely different set of funds. 24:36 24:38 24:39 24:43 24:46 24:49 24:50

Again, that essential health benefit is subject to your existing plan design deductible and out of pocket maximum, and again, the nonessential health benefits is what allows us to not allow any of the spend to be attributed to either deductible or max out of pocket. 24:54 24:56 25:01 25:03 25:07 25:10

And this -- this copay is still applicable, so in the flip to this, let's say you have a member through their existing benefit design that reaches their maximum out of pocket, it does not make the rest of these drugs ineligible because they're in a separate benefit design. So that $1,000 copay is still collectible which allows us to still bill the manufacturer assistance program. And then, unique to the SaveOn program, that member dollar -- that member always has a zero dollar copay. 25:17 25:19 25:22 25:24 25:27 25:30 25:34 25:36 25:40 25:43 25:45

Now, right here is probably a good of place as any to just kind of briefly cover the -- the nuance of the qualified high-deductible HSA plan under the ACA. So we get a lot of questions related to how this is compliant. And where we're at with that is we recognize that there is as requirement under the ACA that patient pay first dollar. So in qualified 25:51 25:54 25:58 26:01 26:06 26:11 26:13 26:15

HSA plans, before patients can receive any additional paid benefit from the plan, they must fully satisfy their deductible out of their own pocket. 26:17 26:21 26:23 26:26

Now, it's a bit of a gray area because we're administering a different benefit design, so do those rules still apply to the SaveOn drug list? And we're in a bit of a conundrum from an industry standpoint because today, copay assistance is not ACA compliant in an HSA plan. In other words, there's no out of station, there's no requirement that patients provide documentation or confirm that they've met their deductible before they get copay attendance. 26:28 26:30 26:36 26:40 26:44 26:48 26:50 26:53 26:58 26:59

So copay assistance happens in qualified HSA plans all the time. We just have little to -- to control that. There's no governing body that's really monitoring that in the industry today. And so what we're faced with is really a plan-by-plan decision. And so we encourage plans to, you know, work with their own legal teams to determine whether or not it's appropriate to include their HSA plans in the SaveOn offering or not. 27:03 27:09 27:11 27:13 27:17 27:20 27:26 27:29 27:31 27:33

MS. GINTER: Yeah, and Rachel, this is 27:36

Melissa again. I had kind of alluded to that at the beginning where we'll spend some time over the next few days working with our compliance resources to kind of take a position on that for IPBC and be able to make that determination. There are, like you said, this is in the gray area where it really is subject to kind of the appetite for risk and the interpretation. And that's something we will facilitate for IPBC. 27:36 27:41 27:46 27:48 27:52 27:55 27:57 28:00 28:03 28:04

MS. HARMON: Great. Yeah, and fortunate for you guys, you have a smaller portion in that category, so the savings is significant, no matter which route you go. 28:08 28:11 28:14 28:17

Okay. So this is the adjudication process that I was referring to earlier. Again, for easy math, we're using some big round numbers, just to walk through some examples. So we're going to say that in this example, the total cost of specialty drug is $10,000. Your current plan design has a specialty copay of $100 and the manufacturer will pay $1,000 per 30-day fill up to $12,000 annually as long as the patient contributes $5 out of their own pocket. 28:20 28:24 28:26 28:29 28:31 28:36 28:38 28:45 28:48 28:52 28:53

So you can see on the next slide what happens without SaveOn. So in today's world and using these assumptions, that $10,000 claim only hits the plan for adjudication, assuming they pass the formulary and UM rule, the plan responsibility is 9,900 and the member copay is 100. 28:54 28:58 29:01 29:05 29:09 29:12 29:14

And if the member is enrolled in copay assistance, they can go after that $100 through the copay-assistance program, but they're still going to have to pay $5 out of their own pocket. The key here is that we know that the copay-assistance program will pay 1,000 per claim, so effectively, in this example, we're leaving $900 on the table with every fill. 29:19 29:24 29:27 29:30 29:33 29:36 29:39 29:41

So when we enroll in SaveOn, we set the copay to correspond to the max that the copay-assistance will allow. So in that primary adjudication point, again, we build a plan, assuming formulary and UM rules are met, the plan responsibility now becomes $9,000, and we pass a member copay of 1,000. Again, we we're not going to communicate that to the member -- we're going to manage that member experience, but once they're enrolled in copay 29:46 29:47 29:50 29:52 29:56 29:59 30:02 30:03 30:06 30:09

assistance, we can then bill our secondary payer. 30:12

Second payer, again, is Pharma. And so Pharma picks up 995, saying, okay, we picked up our part; now, patient, you must contribute $5. The third biller or the tertiary biller is really SaveOn behind the scenes. Administratively, we have a way to bill whatever Pharma doesn't pick up on that secondary adjudication point back to the plan. 30:14 30:18 30:21 30:25 30:28 30:31 30:34 30:35

All of that gets reconciled on your invoice, right? So you're not getting -- that $5 is not counted as savings to you. It's getting passed back, and it's being deducted from your overall savings amount. But this is how we keep our patients whole. 30:37 30:41 30:44 30:46 30:49 30:50

So this allows for the fluctuation in assistance programs. The required amount to pay could be anywhere from $5 to $50, and so we have a mechanism to pass that back to the plan, reconcile the dollars, and ensure the patient always pays zero. 30:54 30:57 31:00 31:03 31:05 31:07

The other things that this process allows for is by ensuring we protect the member experience. So if we assume that the patient 31:10 31:15 31:18

gets 12 fills per year, but they really need 13, we never penalize the member. We don't tell them that they've run out of assistance. The plan has achieved the maximum savings they could by getting the entire year's worth -- or the 12 times $1,000 in savings. And they still get their drug at $0. 31:21 31:24 31:26 31:28 31:31 31:36 31:37

This, also, allows us to maneuver in a somewhat of a dynamic space where we could anticipate changes from Pharma at any time. Knock on wood, we haven't, but in the event that Pharma decides to pull back funding for their program or do decide to change the terms of the program, it's seamless to the member. SaveOn is actively watching these claims process and sees when any of these changes occur and we can either adjust our copay amount so that the invoicing is cleaner on the backend, or it might be a prompt to determine, do we need to make a change in the drug list for this program because we are not saving as much as we initially anticipated, and there's another drug where we could. 31:40 31:44 31:46 31:49 31:52 31:55 31:58 32:01 32:03 32:06 32:09 32:12 32:14 32:17 32:19 32:20

So all of this can happen behind the scenes, but this three-step adjudication process is what 32:23 32:26

really protects the member because once they're enrolled, they're enrolled. They see that they pay $0 time after time. The copay amount could change, sure, but they're not going to see that because they're always going to see that they pay $0 for these claims. 32:28 32:30 32:35 32:37 32:39 32:41

So we feel like that's another differentiator in the market. Not only are we letting the patient have a $0 copay, it's not disruptive at the point of sale, they're not feeling any changes to the program. We're managing it for them on the backend. 32:45 32:47 32:50 32:53 32:54 32:58

All right. And then the next slide I think we talk about the member experience. So you guys have agreed to implement the program, and we generally say it's a 90-day lead time for go live. So that first 30 days is filled with really working on the member communication. We do -- I know there was a question about this earlier. There's a standard member letter that we have that can be co-branded. It can be customized as you see fit. And so in that first 30 days, we're going to nail down the member communication. There are some contractual obligations, so the PHI Release Form, a Business 33:06 33:11 33:13 33:17 33:22 33:25 33:27 33:30 33:33 33:36 33:38 33:40 33:43

Associate Agreement, and then signing something called the joinder, which I believe you guys have already completed those steps. 33:46 33:49 33:51

But in that first 30 days, we want to get all of those details buttoned up because starting two months prior to go live, we want to send that first member communication to our targeted member list. And so it's our goal to outreach to every one of these members before the program ever goes live, which gives us plenty of time for SaveOn to reach out. So we mail the letter, and then a few days following, SaveOn starts on the outbound call campaign where we make three attempts in that first month to enroll the member in the program. 33:54 33:56 33:59 34:02 34:06 34:08 34:11 34:15 34:17 34:20 34:23 34:24

At 30 days out, if we're unsuccessful in reaching those members, we send a reminder letter and again another phone call campaign with attempts to try and get contact with that member and get them enrolled so that at the time you flip the switch on, the program's live, all these claims just process at $0. 34:27 34:29 34:32 34:35 34:38 34:40 34:43

Now, you can see there at the effective date -- we generally get, you can see, 55 to 65 percent of your targeted membership enrolled 34:48 34:51 34:54

before go live, which is great. Now, what happens if they don't get in touch with us before go live, or you have a new patient to specialty medication after the program goes live? That's where the partnership with Accredo is so important. 34:57 35:00 35:03 35:06 35:09 35:11

So I mentioned before that our Accredo advocates -- once a claim is processed, will receive a prompt to alert them that this is a SaveOn drug. And we have some scripting that says, we have an opportunity for you to participate in a program which allows you to get your drug for free; I need to connect you to SaveOn now. 35:14 35:19 35:21 35:23 35:27 35:29 35:31 35:32

And at that point in time, they warm transfer the member to SaveOn, so we stay on the line, make sure they're connected, and then SaveOn does the work to help them understand the program, the terms of enroll and copay assistance and getting them to that program. Once they're enrolled, they give that information to the SaveOn advocate who then relays that to Accredo so that it's housed in our system and then again, the claims from there on out just process at $0. 35:34 35:37 35:39 35:41 35:45 35:49 35:51 35:54 35:57 36:00 36:01

So our goal is to get as many people contacted and enrolled before the program ever goes live, but we do have mechanisms to help assist the member if, again, they didn't contact us beforehand or they're a new patient to specialty after the program's turned on. 36:06 36:08 36:14 36:17 36:22 36:25

All right. And then on the next slide, we have -- we have two different modeling scenarios, and I'll walk through this one. This is your total population, so you can see, just over 43,000 total lives. From that population we estimate that 612 patients will be targeted for the SaveOn program, and if we annualize those claims, it's just over 44,000 claims. 36:35 36:37 36:39 36:41 36:45 36:49 36:51 36:54

We do take into account your existing benefit design. So what we're showing across your membership, which tells me you probably have multiple plan designs, is that our average member contribution per prescription is $32. So when we estimate your $4.9 million in annual fee and saving, we're taking that into account. In other words, SaveOn doesn't take credit for your current plan cost offset by the member contribution. 36:58 37:00 37:03 37:06 37:10 37:14 37:19 37:21 37:24 37:25

So that $4.9 million is less the 37:28

current member contribution. It's less the fee that SaveOn charges to administer your program, which is 25 percent of the savings that's achieved. And so it's -- you have a huge amount. And when you look at the mix, you have just the right mix of specialty utilizers because your per member per month estimated savings is over -- over $9 at $9.38 PMPM. 37:33 37:35 37:39 37:44 37:46 37:49 37:52 37:55

So, again -- 37:59

MS. GINTER: (Inaudible) -- this is Melissa. Let me jump in here. Those of you who participated in the either the sub-pool, the committee, or the board meeting in the last couple of months may not recognize these numbers. These are higher. They've been updated for this particular presentation. 38:01 38:04 38:07 38:09 38:11 38:14 38:17

What we'll do is we will drill into these numbers and come up with the final number once we know which plans it applies to after you've made your decisions at the end of this week, and after we've made the call on HSA plan, then we will be able to factor it in to the rate sheet after the final renewal is published. I saw a question in the chat about how that's going to be handled. 38:20 38:24 38:26 38:28 38:32 38:36 38:38 38:41 38:42

What we will do is the preliminary renewal did not include this savings. The final renewal will be expressed, also, not including the savings. By the time we publish your rate sheet that shows your final rate, that's when we will apply the savings, if you elect to participate in this program. So just from a timing perspective, that's where you're going to see it. And by the time we are able to publish your final rates, that's where we'll roll it in. So just wanted to clarify that from a process perspective, for those of you who have heard parts of this presentation before. 38:45 38:48 38:51 38:54 38:57 39:00 39:02 39:04 39:07 39:08 39:11 39:13 39:16 39:17

MS. HARMON: Great point. Thanks, Melissa. 39:22

MS. GINTER: Um-hum. 39:23

MS. HARMON: And then the next slide highlights what the savings looks like when you exclude your HSA population. As I mentioned before, you have a great opportunity, even if you don't include the HSA lives at $4.7 million annualized. Again, this is net FSE to administer, net your current plan cost offset -- or less your current plan cost offset. 39:25 39:27 39:31 39:33 39:36 39:43 39:47 39:50

Again, the implementation timeline, we've 39:54

already satisfied a significant portion of this, so we're -- we're pretty close to that 60-day-out timeline to finalizing those member communications and getting the green light for you guys in terms of which specific populations to include in enrollment. But again, we'll send those letters out followed by phone calls and then again at 30 days and then when the program goes live. So you guys have done a lot of the heavy lifting in terms of what's required from the client's perspective for implementation of this program. We're just looking forward to SaveOn managing the population once we get the rest of it underway. 39:56 39:58 40:03 40:05 40:09 40:14 40:16 40:18 40:20 40:23 40:26 40:30 40:33 40:36

So -- and because you guys signed the joinder agreement, the invoicing process. So I mentioned there's a 25 percent fee. The joinder agreement allows Express Scripts to bill you for that fee on your administrative invoice. So you'll see a simple line item for SaveOnSP, which is the total amount. But then after implementation, we will be providing you detailed implementation reports, which allows you to see the entire claim and complete flow of money. 40:46 40:50 40:53 40:56 41:01 41:05 41:08 41:11 41:15 41:18 41:19

So when I broke down the example of the primary, secondary, and tertiary bill, there will be a column for each of those amounts. You will see the total cost of drugs, plus the copay that we charged, less the amount the copay-assistance paid, and then a column for any amounts that we had to pass back to the plan, and then your total savings, which is how we actually calculate -- calculate the -- the amount of savings to calculate the fee. Besides that, we would -- so we'll have detailed monthly invoicing reports, and then quarterly, we can provide, you know, higher-level reporting package type results. 41:21 41:24 41:27 41:29 41:32 41:34 41:37 41:39 41:45 41:53 41:55 41:58 42:01 42:03

So I think that's the end of my presentation. I can bounce back to chat and kind of cover the questions that we didn't cover in my presentation, or, Melissa, how do you -- how would you prefer I wrap up here? 42:08 42:11 42:14 42:16 42:19

MS. GINTER: So let's -- let's open it up for questions. The next question that's in the chat that we didn't get to is, what does the member pay once they hit the maximum allowed under the program? 42:21 42:24 42:26 42:29 42:30

MS. HARMON: The member always pays zero. 42:34

As long as they're enrolled and as long as the drug is in the program, if they've maxed out the copay assistance, then the plan has done the best that they can, meaning they've achieved their offset using the entire amount of assistance that Pharma will pay for that entire year. 42:38 42:40 42:42 42:45 42:48 42:50 42:51

MS. GINTER: Great. Next question. When we talked about kind of the primary, secondary, and tertiary claim payments, I think there's -- there's a question around does the member have to initially pay the $1,000 to receive the medicine, and then wait for reimbursement? Or is all of that behind the scenes and automated? 42:58 43:01 43:04 43:05 43:08 43:11 43:13

MS. HARMON: Good question. Not at all. It should be all behind the scenes and automated. So the only visibility that the member will have is, one, through the letter that includes the drug list and the corresponding copays. And it's made clear that as long as they participate in the program, they pay zero. And the other place would be on the invoice paperwork, they could see where the copay was listed as $1,000, but they will not be charged the $1,000. 43:15 43:18 43:22 43:24 43:27 43:29 43:35 43:40 43:41 43:46

So we do a pretty good job in terms of 43:49

explaining it, I think, in the member letter proactively. And then, as part of the conversation SaveOn has with the member, they do their due diligence to explain, you know, we're charging a copay to be able to create The savings, but you will always pay zero, as long as you are enrolled in the program. 43:51 43:54 43:56 43:59 44:01 44:03 44:05

MS. GINTER: Great. Okay. The next question is, if an employee ignores the communications that they've received on the program, when and how will they first become aware or experience the plan changes while attempting to fill their prescription? So -- 44:11 44:14 44:15 44:19 44:22 44:24

MS. HARMON: Yep, absolutely -- 44:25

MS. GINTER: -- prescription of right here. 44:27

MS. HARMON: Yeah. So whenever -- and I think I used the words that we (inaudible) a warm transfer, we get a prompt in our system. That prompt for an advocate is actually a rejection. So I don't like to use that word in this capacity because we're not telling them that the claim's not paid, but it's the prompt for our Accredo advocate to recognize that it is a SaveOn prescription. And the claim cannot move further until we either have the override, which 44:31 44:33 44:34 44:37 44:40 44:42 44:45 44:48 44:51 44:54

is the copay assistance information to put in the system to get it to zero. So we will not advance that any further. And if we have difficulty getting the member connected with SaveOn, or if it's an instance where we've tried to reach out to the member and the member's not getting back to us, we then, engage you to let you know that we're having difficulty. 44:57 44:59 45:03 45:06 45:08 45:10 45:15 45:16

So we don't want to have disruption. We want members to be able to get their medication. We stay very engaged with these patients, and we track their success in terms of enrollment. So you would find out before -- you know, if we had any difficulties, so we would not -- we would not tell the member they couldn't get their medicine or -- or anything to that effect, that we would be coordinating with them to the best of our ability and then to you if we had difficulty. 45:19 45:21 45:24 45:28 45:33 45:36 45:38 45:38 45:42 45:43 45:45

MS. GINTER: What would the member be asked to pay if they refused to enroll in the program at the point of sale or with any outreach? 45:48 45:52 45:54 45:54

MS. HARMON: That's an excellent question. So what we do at that point in time is if they 45:58 46:01

refuse to enroll, that's when SaveOn reaches out to Tammy and I and we engage you. Our recommendation is to always uphold the plan design, meaning if you don't participate in this program, your copay, or your responsibility will be $1,000. And because it's not part of your existing benefit design, that $1,000 is not applicable to your max out-of-pocket. And that's often compelling enough for members to say, oh, wait, I'm going -- I want my drugs for free, right? 46:03 46:06 46:09 46:13 46:15 46:19 46:21 46:25 46:28 46:30 46:31

If that's not a successful message, or if you have concerns for that message, we will work with you in terms of how you want to manage those patients. We have some clients with union populations like yourself that feel strongly that they have to have the ability to override. And you should know that you absolutely have that ability. We -- we ask that you do so cautiously because we don't want to undermine the plan design you're putting in place to create savings. So if members realize that they can simply say no and opt out, we're sort of defeating the purpose. 46:34 46:37 46:40 46:45 46:47 46:50 46:52 46:56 46:59 47:01 47:05 47:07 47:07

The flip to that is if you have a really 47:11

escalated member and you have a sensitive situation where you feel like it's appropriate to provide that override, we absolutely can do so. Just know that we can't override the plan design, meaning we can give the patient an override to mirror what your specialty copay is on your existing benefit design. So again, if that's $25, we can say, okay, we'll put an override in; your responsibility is $25. But it doesn't change the fact that it's carved out and nonessential. 47:13 47:15 47:18 47:22 47:24 47:28 47:31 47:34 47:37 47:40 47:41

So when they pay that $25, it is not applicable to that max out-of-pocket. And that's just a really important distinction that we all understand. So you can override it; you can put it at zero and forgo any -- any plan cost savings. We don't recommend it, but we recognize that there are situations where you might feel that that is necessary. And so we can support any of those scenarios. We just work with you if and when that happens. 47:43 47:47 47:48 47:52 47:55 47:58 48:00 48:04 48:07 48:09

MS. GINTER: And for IPBC members, those kind of decision points go back through the cooperative. We have to be a little sensitive to the fact that this is shared risk within the 48:12 48:15 48:16 48:19

cooperative, and that that is -- is a decision 48:22

that generally, is made at the cooperative 48:25

level. So just works a little different with 48:29

the fact that this is kind of a combined, 48:31

multi-employer arrangement. 48:33

Okay. Next question. Why can't Express 48:39

Scripts just include any members who are on 48:41

the specialty drug in the program, rather than 48:42

making them individually register for the 48:44

program? Rachel? 48:56

MS. HARMON: So, again, this is an 48:57

agreement -- (inaudible). 48:58

MS. GINTER: Oh no, we lost you. 49:04

MS. HARMON: Can you hear me? 49:04

MS. GINTER: You're cutting out. Can you 49:05

Maybe start at the top again -- 49:06

MS. HARMON: Okay. 49:06

MS. GINTER: -- with the answer to that 49:07

question? 49:09

MS. HARMON: Sure. You can hear me, 49:11

correct? 49:15

MS. GINTER: Yes, now we can. 49:15

FEMALE VOICE: Now we can, um-hum. 49:16

MS. HARMON: Okay, okay, okay. Sorry. 49:18

So again, this is an agreement between -- 49:21
between the patient and copay assistance 49:22
through the manufacturer, so in order for us 49:27
to leverage the savings, the member has to 49:29
actively enroll in copay assistance. That's 49:33
where the savings come from. We can't do that 49:35
for a member. They have to do it on their own. 49:37
MS. GINTER: Okay. The next question is 49:45
on someone who uses an HSA outside of their 49:49
current plan. Joan, we'll -- we'll respond to 49:52
that individually. I -- I want to be careful to 49:54
make sure we give you an accurate answer, so I 49:57
have to follow up with you on that one. 49:59
The next question is, if an employee 50:03
currently pays the copay to obtain their 50:06
prescription, are they even aware of the 50:08
manufacturer assistance, and will they -- 50:10
they even understand what this is? 50:12
MS. HARMON: Yeah, so it's an interesting 50:15
dynamic. Our specialty patients are very aware 50:18
of copay assistance. And if you listen to drug 50:23
ads on TV, at the very end, there's always a 50:26
tag line, if you can't afford your medication, 50:29
ask us how we can help, right? 50:31
And so, our specialty patients are often 50:35

part of different communities and different support groups where these things are actively talked about. And so what we often see -- you guys have a very generous plan design, but in plan designs that are -- have higher patient responsibility, we often see that most patients use copay assistance in those plans because of the cost. 50:37 50:39 50:43 50:45 50:49 50:52 50:54 50:53

And we have to -- honestly, we see it when cost isn't an issue. Whether they need it or not, if they know copay assistance is out there, they're getting it. So they're probably aware, and if they're not, that's SaveOn's job to help -- help them understand what we're going after here and -- and how we're getting the savings for them in the plan. 50:57 51:00 51:02 51:06 51:08 51:11 51:13 51:14

MS. RYKIEL: And I would just interject there, Rachel and Melissa, that, in fact, last year in -- we saw that 317 IPBC patients did utilize copay assistance to help offset their specialty copays. 51:17 51:21 51:25 51:29 51:38

MS. GINTER: And maybe that's a good time to ask the question, it seems like Express Scripts is trying to take advantage of the the manufacturer copay assistance program that 51:39 51:40 51:43 51:45

were intended to help low-income patients who cannot afford their copays. At what point do the drug manufacturers decide to eliminate these programs when they realize they're being used to basically reduce the cost of employers and those who may not need assistance? 51:48 51:50 51:53 51:54 51:58 52:00

MS. HARMON: Oh, that's a good one. So I'll clarify by saying there are two different types of assistance out in the -- well, there's really three. One is free drug, and that's administered by the manufacturer directly in the industry. Second is foundational support, which is the charitable organizations that put forward funds to help patients in need. Now, charitable -- those foundation support programs have lengthy requirements for getting those funds. 52:03 52:07 52:09 52:12 52:14 52:17 52:19 52:22 52:24 52:28 52:28

Think of this like scholarship money, right? They have to submit application, their W-2s, their monthly -- like, an income and expense statement. They have to prove that they are truly in need financially of those funds. What we target in SaveOn is manufacturer assistance programs that are not part of foundational support. We purely view these 52:31 52:33 52:36 52:38 52:42 52:47 52:50 52:52

funds as marketing dollars. 52:54

So Pharma's put, we estimate, roughly 52:56

$15 billion in the industry of copay assistance 53:00

programs today. And, you know, they do it 53:03

under the guise of making their drugs more 53:04

affordable and accessible to the patients that 53:07

need them. But they do get significant tax 53:10

write-offs for -- for those types of program 53:13

offerings, and also, we know that they put 53:16

those programs out there to really preserve 53:18

market share in their product. 53:20

So far, we have seen some reactions from 53:25

manufacturers because of copay assistance 53:28

programs, but most of the reactions kind of 53:31

related to the accumulator adjustment programs. 53:34

And the reason for that is, when you use an 53:39

accumulator adjust program and you're constantly 53:41

resetting their max out-of-pocket, removing the 53:44

copay assistance, when you have a patient in a 53:47

high-deductible plan where they can meet their 53:51

max out-of-pocket in the first three fills, 53:53

they also, exhaust the funding for the year for 53:56

these copay assistance programs. 53:57

And what would happen is, they would start on 54:02

a drug, exhaust the funding, and then flip to a 54:04

competitor's drug. And that's really what Pharma has reacted negatively to, which tells us the pure reason for them putting these dollars on the table is to ensure that they have patients using their drug, not -- not any drug. So it's not to say that we couldn't see other reactions. Most of the -- the changes to programs we've seen in the marketplace are really focused on the accumulator adjustment because it exhausts and then it makes them flip to another drug. 54:08 54:11 54:14 54:15 54:19 54:23 54:27 54:29 54:31 54:34 54:34

For SaveOn, we've been successful because we're keeping them on the same drug. We're just leveraging the assistances they've put on the table. 54:39 54:42 54:44 54:46

MS. GINTER: Thanks, Rachel. The -- the Next question I'll answer real quick. And then in the interest of time, we're going to have To switch over to just a quick walk-through of The opt-out form. 54:52 54:54 54:56 54:59 55:00

The question to everyone is, why the 5/1 effective date for IPBC? Why not wait until the renewal? That is a decision that was based on the dramatic savings involved. Here, these are real dollars in -- in a year that we know 55:03 55:06 55:10 55:14 55:17

that many local budgets are being subject to a serious amount of pressure to find dollars. This is one of those things that's a win-win for employees. They get their copay subsidized, and for IPBC to allow these dollars to flow through. And so there was some urgency in rolling this out as soon as possible to take advantage of the savings. So that's why the unusual timing in here. But knowing that it has potential -- the potential, you know, to be concerning to you, that's why we wanted to develop this process that you see on your screen right here. 55:20 55:22 55:25 55:28 55:31 55:33 55:35 55:37 55:40 55:42 55:46 55:48 55:50

This is the opt-out form. If you look at this program and for whatever reason decide that it -- it is not something you feel is appropriate for your employee base, you do have the ability to opt out. Based on the board vote, everyone will have this rolled out, with the exception of grandfathered plans and, possibly, HSA plans. If you want your own plans excluded from this program, you need to fill in this opt-out form. This will be distributed. We post it on the IPBC website. I'll work with Sandy to make sure it gets sent out, as well, if it hasn't been 55:52 55:56 55:58 56:01 56:04 56:07 56:10 56:13 56:17 56:21 56:24 56:25

already. But this is the form that will notify myself and Dave Cook that you do not want this program rolled out. Because of the urgency in the implementation, the deadline for this is this Friday. So you've got the chance now to review this material and consider what you've heard here today, and then you can take a look at this -- this form and complete it, if it's something you would like to opt-out of. 56:28 56:32 56:36 56:38 56:42 56:45 56:48 56:51 56:54

I know that there were a handful of questions. We can keep going for a few minutes, and if you put a question in the chat box that was not addressed, we can follow up with you via email after the meeting. So -- but wanted to make sure that we had a chance to discuss this form because this is kind of the action needed on your part, if you're concerned about the implementation of this program for your community. 56:57 56:59 7:02 57:05 57:08 57:11 57:13 57:16 57:18 57:19

So with that, Dave or Sandy, do you want to add any comments to wrap up or anything additional to add? 57:23 57:28 57:32

MR. COOK: Melissa, there was just a -- a question regarding can we send the answers to everyone? We can format the questions and 57:36 57:40 57:43

send out the form and the responses all together later today, I hope. 57:45 57:48

MS. GINTER: Sounds good. Okay. Well, Rachel, you've been enormously helpful. Really appreciate the time to do the presentation today. Thanks, Tammy, for helping pull all this together. And I appreciate the engagement and all the questions we got. Thank you very much on the part of IPBC members, as well, and for you really paying attention to this important issue that is being rolled out for IPBC. So this recording will be posted on the website, along with the slides and the opt-out form. And we'll send out the answers to questions that we didn't get to later on. So thanks, everybody. 57:59 58:01 58:03 58:05 58:08 58:11 58:14 58:16 58:20 58:22 58:25 58:28 58:32

FEMALE VOICE: Thank you. 58:35

FEMALE VOICE: Thank you. 58:35

(End of Video Recording.)

# CERTIFICATE

I, Wendy Sawyer, do hereby certify that I was authorized to and transcribed the foregoing recorded proceedings and that the transcript is a true record, to the best of my ability.

DATED this 15th day of June, 2022.

WENDY SAWYER, CDLT